MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Rehabilitation Clinics

September 2005 • Bulletin 371

Contents

2005 CPT-4/HCPCS Updates: Implementation November 1, 2005

The 2005 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2005. Specific policy changes are highlighted below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

Vaccine For Children Program

New CPT-4 code 90656 (influenza vaccine [for recipients 3 years of age and older]) is reimbursable under the Vaccines For Children (VFC) program and must be billed with modifiers -SK (high risk) and -SL (state supplied vaccine). CPT-4 code 90700 (DTaP vaccine) is now restricted to recipients younger than 7 years of age.

Conversion of Interim Modifiers and Notice of Public Comment Period

HIPAA mandates that national modifiers replace interim HCPCS modifiers for use in Medi-Cal billing. Effective for dates of service on or after November 1, 2005, interim modifiers -YQ, -YS, -ZK, -ZU and -ZV will be replaced with new national modifiers as indicated below.

A public comment period is ongoing until September 30, 2005. (See below for more details.) Absent any grave concerns arising from the public comments, the Department of Health Services (DHS) will proceed with the modifier changes listed below. The policy of the interim modifier applies to the replacement modifier.

Interim Modifier	Replacement National Modifier
-YQ (Certified nurse midwife service)	-SB (Nurse midwife)
-YS (Nurse practitioner service)	-SA (Nurse practitioner with physician)
-ZK (Primary surgeon)	-AG (Primary surgeon)
-ZU (Exception modifier to 80 percent reimbursement [medical necessity; outpatient setting])	**Two modifiers required:** -22 (Unusual procedural services) **and** -SC (Medically necessary service/supply) **and** Facility Type Code 13 or 83 **or** Facility Type Code 14 **plus** Frequency Code 1
-ZV (Exception modifier to 80 percent reimbursement [non-hospital compensated physician; emergency service])	**Three modifiers required:** -22 (Unusual procedural services) -SC (Medically necessary service/supply) -ET (Emergency services)

Please see **Conversion of Modifiers**, *page 2*

Conversion of Modifiers *(continued)*

Note: When billing for the exception to 80 percent reimbursement, modifier -22 must be the first modifier listed on both the *Treatment Authorization Request* and claim form in order for the claim to reimburse correctly.

Comment Period
Notice is hereby given that DHS will conduct written public proceedings, during which time any interested person or such person's duly authorized representative may present statements, arguments or contentions (hereafter referred to as "comments") relevant to the action described in this notice.

Comments must be received by DHS by 5 p.m. on September 30, 2005, which is hereby designated as the close of the written comment period. All written comments to DHS, including e-mail, mail or fax transmissions, must include the author's name, organization or affiliation and telephone number.

Comment Instructions
The Medi-Cal Comment Forum page includes links for e-mail comments by "Providers," "Medi-Cal Managed Care Plans" or "General Public." The "Medi-Cal Comment Forum" page is located in the HIPAA News section on the Medi-Cal Web site (**www.medi-cal.ca.gov**). Providers should select the "Medi-Cal Comment Forum" link, enter comments in the body of the e-mail and send it to the pre-formatted address in the "To:" line.

Note: E-mail is not confidential, so users should be cautious when entering confidential or sensitive information. Email addresses will not be shared with outside parties, but may be used for future DHS mailings.

Comments may also be submitted by mail or fax to:

Medi-Cal Comment Forum
P.O. Box 13811
Sacramento, CA 95853
Fax: (916) 638-8976

All written comments to DHS, including e-mail, mail or fax transmissions, must include the author's name, organization or affiliation and telephone number.

Health plans are requested to centralize their comments and send them to DHS through their designated HIPAA contact person.

HIPAA Code Conversion for Respiratory Care Practitioners

Effective November 1, 2005, billing codes for respiratory care practitioners will be revised in compliance with HIPAA. The following interim HCPCS codes will be terminated:

- X4700 (respiratory care evaluation)
- X4702 (respiratory care case conference)

Respiratory care practitioners must now bill for their services with the following Evaluation and Management CPT-4 codes:

- 99202 (office visit, new patient, level 2)
- 99212 (office visit, established patient, level 2)

Code 99202 may be billed by a respiratory care practitioner once every three years, however, the recipient must not have been seen for any reason during the preceding three-year period by the same respiratory care practitioner.

Code 99212 may be billed by a respiratory care practitioner once in six months by the same provider, for the same recipient, with prior authorization.

Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update*.

CPT-4 Procedure Codes and Modifiers Billing Reminder

Providers are reminded that they must select the appropriate CPT-4 code and modifier when billing. The CPT-4 code descriptor must match the procedure performed. *This information is reflected on manual replacement page ub comp op 19 (Part 2).*

FFS/MCN Information Removed from Manual

Fee-for-Service/Managed Care Network (FFS/MCN) pilot program information is being removed from the provider manual. FFS/MCN was terminated effective for dates of service on or after July 1, 2003. Information about the program, which consisted of Placer County Managed Care Network (Health Care Plan [HCP] 640) and Sonoma County Partners for Health Managed Care Network (HCP 642), was retained in the provider manual for a period of two years to help providers with final billing.

Providers should remove pages mcp ffs bil 1 thru 5 (Part 2) from their manuals.

Inpatient Provider Cut-off Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claims transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cut-off dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: *Contents for Rehabilitation Clinics Billing and Policy iii/iv* *
cal child bil 1/2 *

Remove the section *MCP: Fee-For-Service/ Managed Care Network (FFS/MCN) Billing Guidelines*: mcp ffs bil 1 thru 5

Remove and replace: modif app 3/4 *
ub comp op 19/20

* Pages updated due to ongoing provider manual revisions.